NETWORK ADEQUACY STANDARDS AND GUIDANCE

Section 3241 of the Insurance Law requires insurers, including municipal cooperative health benefit plans and student health plans, that issue a health insurance policy or contract or a dental policy or contract with a network of providers to ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. This requirement applies beginning March 31, 2015 upon Department of Financial Services (DFS) approval of all new policies and contracts and upon application for the expansion of any service area associated with the policy or contract. The following provides information about the network adequacy requirements and standards.

1. Applicability

- DFS will review provider networks that will be used with a health insurance policy or contract, or a dental policy or contract, that have not been approved by the Department of Health (DOH).
- **Same Network as NYSOH.** If an insurer uses the same network for an insurance product offered outside the New York State of Health (NYSOH) that has been approved by DOH for an insurance product offered inside NYSOH, the insurer will need to certify to DFS that the network is the same. DFS will deem the network adequate if it has been approved by DOH.
- **Same Network as HMO.** If an insurer uses the same network for an insurance product that has been approved by DOH for a HMO product, the insurer will need to certify to DFS that the network is the same. DFS will deem the network adequate if it has been approved by DOH.
- **Same Network as NYSOH or HMO in Some Counties.** If an insurer uses the same network for an insurance product offered outside NYSOH that has been approved by DOH for an insurance product offered inside NYSOH or for an HMO, but would like to add additional counties that have not been approved by DOH, the insurer will need to (1) identify the counties that have been approved by DOH and the counties that have not been approved by DOH; (2) certify to DFS that the network, in the counties approved by DOH, is the same; and (3) provide the requisite information to DFS for review of the additional counties that were not approved by DOH.
- **Network with More Providers Than Approved for HMO or NYSOH.** If an insurer uses a network for an insurance product offered outside NYSOH that has the same or more providers in each provider type and county than a network approved by DOH for an insurance product offered inside NYSOH or for an HMO, the insurer will need to certify

to DFS that the network has more providers than the network that was approved by DOH. DFS will deem the network adequate if it has more providers than the network that was approved by DOH. If there are any provider types in any counties that have fewer providers than approved by DOH, the insurer will need to (1) identify the counties that have more providers than the network that was approved by DOH and certify that the network is the same as DOH approved for those counties, except for the additional providers; (2) identify the counties that have fewer providers than approved by DOH and the provider types; and (3) provide the requisite information to DFS for review of the counties that have fewer providers than approved by DOH.

- **Network with Fewer Providers Than Approved for HMO or NYSOH in Some Counties.** If an insurer uses a network for an insurance product offered outside NYSOH that has fewer providers in some counties than approved by DOH for an insurance product offered inside NYSOH or for an HMO, the insurer will need to (1) identify the counties that have the same network as approved by DOH and certify that the network is the same as approved by DOH; (2) identify the counties that have fewer providers than the network that was approved by DOH and the provider types; and (3) provide the requisite information to DFS for review of the counties that have fewer providers than approved by DOH.

2. Review of Networks

Once it becomes available, insurers should submit their networks to DFS for quarterly review through the Provider Network Data System (PNDS). DFS will supply instructions for insurers to use when submitting their provider networks through PNDS. Until such time that the PNDS becomes available, networks should continue to be submitted to DFS through the System for Electronic Rate and Form Filing (SERFF), the online portal insurers currently use for form and rate submissions.

Insurers should continue to reference their network submissions when filing a policy form or contract for approval. The filing should indicate whether it is using an approved network, or an unapproved network. Networks not yet approved will need to be submitted for approval. Networks will be reviewed on a quarterly basis through the PNDS when it becomes available.

3. Standards For Review Of Provider Networks

- When establishing a network, an insurer should consider: anticipated enrollment; expected utilization of services by the population to be enrolled; the number and types of providers necessary to furnish the services covered in each product; the number of providers who are not accepting new patients; and the geographic location of the providers and enrollees.

- To be considered accessible, the network should contain a sufficient number and array of providers to meet the diverse needs of the insured population and to ensure that all services will be accessible without undue delay. This includes being geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.
- DFS will be using the same standards as DOH uses to determine network adequacy. In general, these standards include the following for medical coverage:
    - At least one hospital in each county; however, for Bronx, Erie, Kings, Monroe, Nassau, New York, Queens, Suffolk, and Westchester counties the network should include at least 3 hospitals;
    - A choice of 3 primary care physicians (PCPs) in each county, and potentially more based on enrollment and geographic accessibility; and
    - At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility.

4. Service Area

For network adequacy purposes, a service area is defined as a county. For counties other than Bronx, Kings, New York, Queens and Richmond, the county will be "extended" to include portions of adjacent counties because of health care resources and the utilization patterns of consumers ("expanded county area"). This extension will expand the county border approximately 10 miles into contiguous counties.

5. Network Composition

The insurer's network should contain all of the provider types necessary to provide services under the insurance product, including but not limited to with respect to medical coverage: hospitals; physicians (primary care and specialists); mental health and substance use disorder treatment providers; allied health professionals; ancillary providers; durable medical equipment (DME) providers; home health providers; and pharmacies. DFS may ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

6. Time and Distance Standards For Primary Care Providers

- Metropolitan Areas: 30 minutes by public transportation.
- Non-Metropolitan Areas: 30 minutes or 30 miles by public transportation or by car.
- In rural areas, transportation may exceed these standards if justified.

7. Time and Distance Standards For Providers That Are Not Primary Care Providers

- It is preferred that an insurer meet the 30 minute or 30 mile standard for other providers that are not primary care providers.

8. Providers That Should Not Be Included in an Insurer's Network

An insurer should not include in its network any provider who:

- Has been sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
- Is deceased; or
- Had his/her license suspended or revoked by the New York State Education Department or the NYSDOH Office of Professional Medical Conduct.

9. Behavioral Health Providers For Medical Coverage

- An insurer should include individual providers, outpatient facilities and inpatient facilities in its behavioral health network. The network should include facilities that provide inpatient and outpatient mental health and inpatient and outpatient substance use disorder treatment services. Facilities providing inpatient substance use disorder treatment services should be capable of providing detoxification and rehabilitation services.
- An insurer should advise participating providers that conversion therapy should not be provided to an insured and that the insurer will not provide reimbursement for such services. As part of the insurer's provider credentialing or application and re-credentialing processes, insurers should require behavioral health providers to certify that they will not provide conversion therapy to an insured or seek reimbursement from the insurer for such services. Conversion therapy means any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

10. Dental Coverage

- An insurer's dental network should include geographically accessible general dentists sufficient to offer insureds a choice of 2 primary dentists within each county in the network and to achieve a ratio of at least 1 primary care dentist for each 2,000 insureds.
- Networks should include at least the following providers: 2 orthodontists (unless the network is used only with products that do not contain an orthodontic benefit), 1 pedodontist and 1 oral surgeon. A general dentist who is willing and able to treat

children may be designated as a pedodontist for network adequacy purposes. The network filer should provide a statement indicating the filer verified that the general dentists designated as pedodontists are willing and able to treat children.

- Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics should be provided through any qualified dentist, either in-network or by referral.
- Periodontists and endodontists should be available by referral.
- The network should include dentists with expertise serving special needs populations (e.g. HIV+ and developmentally disabled patients).
- A time and distance standard of 45 minutes/45 miles may be used for the following rural counties for the following provider types:
    - Pedodontist: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins.
    - Oral Surgery: Essex, Franklin, Lewis, Schoharie and Steuben.
    - Orthodontics: Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.

11. Stand-Alone Vision Coverage

- A stand-alone vision network should include the following provider types in each county (or expanded county area): 2 ophthalmologists, 2 optometrists, or 1 ophthalmologist and 1 optometrist.